

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA

SECTION I: *to be completed by hospital*

Name of Hospital <div style="text-align: right;">B1</div>	Street Address <div style="text-align: right;">B2</div>	City or County <div style="text-align: right;">B3</div>	State <div style="text-align: right;">B4</div>	ZIP Code <div style="text-align: right;">B5</div>
Hospital Provider Number <div style="text-align: right;">B6</div>	Total Number of Beds <div style="text-align: right;">B7</div>	Total Number of Certified Beds <div style="text-align: right;">B8</div>	Other Data — Does the hospital operate a forensic unit? <div style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="text-align: right;">B9</div>	

For the past year: A. Total number of admissions to certified areas from (month)_____ (year)_____ <div style="text-align: right;">B10</div>	B. Age Range of Patients <div style="text-align: right;">B11</div>												
C. Medicare/Medicaid Billings <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 20%;">Billed</th> <th style="width: 20%;">Collected</th> </tr> </thead> <tbody> <tr> <td style="background-color: black; color: white; text-align: center;">MEDICARE/Part A</td> <td></td> <td></td> </tr> <tr> <td style="background-color: black; color: white; text-align: center;">MEDICARE/Part B</td> <td></td> <td></td> </tr> <tr> <td style="background-color: black; color: white; text-align: center;">MEDICAID</td> <td></td> <td></td> </tr> </tbody> </table>		Billed	Collected	MEDICARE/Part A			MEDICARE/Part B			MEDICAID			D. Other Data — Does the hospital operate a separate MEDICAID ONLY-Residential Treatment Program for Psychiatric patients under the age of 22? <div style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="text-align: right;">B12</div>
	Billed	Collected											
MEDICARE/Part A													
MEDICARE/Part B													
MEDICAID													

13. Current Hospital Statistics *(on days of survey) [certified beds only]*

Name of Ward	Bed Capacity	Patient Census
		Total Patient Census

B13

SECTION II: *to be completed by the survey team*

19. Certification of Findings

I certify that I have reviewed each Condition of Participation and Related Standards for Psychiatric Hospitals, and unless indicated on the CMS-2567, the Facility was found to be in compliance with the Conditions and/or Standards.

Signature	Title	Date
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date